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The Use of the ADHD Diagnostic Label: What Implications Exist for Children and Their Families?

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Abstract

ADHD is considered an impairing psychological disorder that predominantly affects children and is characterised by inattention, impulsivity and hyperactivity. This diagnosis has become controversal in literature do to the conceptual resistances expressed by clinicians and pediatricians in considering a simple list of behaviors as a psychological syndrome, in absence of physical test or single cause demonstrating it. They have to be considered implications linked to the overuse of the diagnostic label; within these, the risk (by teachers and school managers) of justifying and supporting interventions for differentiating teaching strategies and menaging difficult student-case, the financing of which would be impossible without diagnosis. As a result, a considerable amount of research has been completed in recent years to better understand the phenomenon. In the present paper features for and against the use of the diagnosis will be present and discuss apart from the critical analysis of different frameworks and by introducing a relational perspective deriving from the labeling theory and interactionism. Operational suggestions and strategies for teachers and families dealing with minors are also presented, both in schools and in clinical setting.

Keywords: Attention-Deficit/Hyperactivity Disorder, Diagnosis, Labelling.

1. Introduction

Attention-deficit/hyperactivity disorder (ADHD) is the name with which you identify a "symptomatic" framework characterized by behaviors that are considered dysfunctional primarily inattention, impulsivity, and hyperactivity. Historically, ADHD takes the place of the old discussed "hyperactive child syndrome," first known as "minimal brain damage" (until the end of the year 1960) and then as "minimal brain disorder" (minimal brain

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dysfunction in the Diagnostic and Statistical Manual of Mental Disorders-DSM-III, 1984). Lastly, the definition was amended due to not having a more explicit reference to damage or to a cerebral dysfunction.

Studies and research that have focused on ADHD in the recent past are remarkable, involving various professionals: psychologists, psychiatrists, educators, sociologists, and teachers. In particular, the professionals who work in the school setting are very interested because attention and hyperactivity are two processes that may affect scholastic participation.

Studies on the subject have not yet clarified some important aspects of ADHD (they are missing the etiology, and the diagnostic process is ambiguous); nevertheless, the category of ADHD is used in school contexts to explain some children's behaviors and to identify the most appropriate intervention strategies.

2. Identifying ADHD: What are the Issues?

Identifying so-called ADHD is a complex task: First, despite the enormous production of studies and research today, no diagnostic tests (biological, genetic, or radiological) can identify with certainty "Disorder of Attention Deficit/Hyperactivity Disorder," as confirmed[†] by the DSM-IV (American Psychiatric Association [APA], 1994) and the National Institutes of Health (NIH, 1988) as well as other authors (Baughman, 2006; Breggin, 2002; DeGrandpre, 1999; Leo, 2000; Peterson, 1995; Zametkin, Ernst, & Silver, 1998).

Second, the diagnosis is not founded on objective signs and symptoms but rather is subjective. In fact, ADHD is not a well-defined biological entity but rather a set of behaviors that are considered dysfunctional. Is that a syndrome and not a "disease?"[‡]

Third, the ADHD diagnosis requires the active collaboration of other roles: on one side, teachers and parents; on the other side, specialists (scholastic psychologists and clinical psychologists, psychiatrics, doctors, neurologists, and social workers) who assume the responsibility of the reporting and description of the behavior (Angold, Erkanli, Egger, & Costello, 2000; Panei, 2009; Wolraich, 2000). These segnalations are carried out often on teachers and parents not "prepared" and they haven't the shared criterias of observation.

Moreover, the criteria that the APA[§] has defined are the same regardless of the child's age and stage of development, as the behaviors of children (and their meanings) also vary according to the children's growth states.

A fourth element that complicates the diagnostic evaluation of ADHD is that some of these symptoms coexist in other disorders in 70–80% of cases; this phenomenon is called comorbidity.

3. Psychologic Relapses on Children

An initial effect of an ADHD diagnosis is the induction of the belief that one has found the **cause** of a child's problematic behavior. The expectation of parents is to eliminate the child's problematic behavior, with many parents actually experiencing relief and gratitude after learning that their children's problems are not dependent on them but rather on their children's "neurodiversity" (Diller, 1998). Soon, however, the teachers and parents of a child who has been diagnosed with ADHD realize that the "cause" has not been eradicated, so they must resume

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[1] Can you consult Mannuzza, S., Klein, R.G., Moulton, J.L., 2003.

[2] The disease is characterized by certain etiology and refers to objective evidence, the signs, so called because it freed from the categories of knowledge of the operator (semiotic framework). The signs are in fact distinct from the symptoms, which instead are not a single entity phenomenal and therefore are not characterized by any standardization.

[3] For disputes that rise from the current diagnostic definition of "'ADHD," like that of other categories contained in the DSM, you can see (Caplan, 1996). For the difficulties regarding determining this disorder and the critical issues related to compliance with the criteria of validity and reliability, you can see (Timimi et al., 2004). The current epidemiological studies, all seemingly "serious and in-depth," produce very different diffusion rates, from 0.1% to 26% of children (Poma, 2006).

managing the child's behavior in the classroom, as the diagnosis does not require the removal of the child from the classroom setting (Graham, 2008). The implication of diagnosis, however, involves the **labeling of children,** and therefore, the classroom management may be affected by this (Iudici, Faccio, 2013a).

It is also possible that the ADHD diagnosis for the child turns out to be a "stigma" with which to interpret his or her future life [college, work, relationships, etc.] (Canu, Newman, Morrow, & Pope, 2008; Iudici, Faccio, 2013b). Following diagnostic labeling, children will learn to use the attitude of "disengagement" and irresponsibility that adults have implemented against them. For example, in the case of success or "appropriate" behavior, diagnosed children will award the credit to their medications[**]; if they fail, they will think that the disease is stronger than what they can do. Mostly, however, they will give coherence to the feeling of being "different"—to think that medication or the disease attributed to them mediate something in their brains and in their relationships with the world (Singh, 2007).

Classroom management is particularly complicated because the child, from diagnosis forward, is in a position **to justify** any of his or her behaviors (Carpenter & Austin, 2008). For the family, the diagnosis is often used to ask the teacher to adjust the assessment of the child's behavior and performance in light of the same diagnosis. The greatest common denominator between parents and teachers of this process is **not to focus on the resources of "the child"**—on how he or she can learn to handle the demands of the context (Gleeson & Husbands, 2001; Iudici, 2013). Justifying the child's behavior and not urging its resources begins a process of the **reduction of opportunities for development** and of the legitimization of the role of being "different" or "sick." The diagnosis also limits, as several authors have reported, the collaboration between those who are engaged in identifying management strategies, such as teachers, psychologists, educators, and parents (Angold & Erkanli, 2000; Carey, 2004; Salvini et. al, 2012).

All parties share, implicitly and explicitly, the belief that the responsibility for the child's behavior can be attributed to a deficiency or disease. This essentially limits the contribution of the various roles involved in the child's life, both with respect to the strategies identified and with respect to the errors that parents or teachers have committed (Singh, 2003; Jones et al., 2008; Iudici A., de Aloe S., Fornaro G.,, Priori M., Strada A., 2013).

4. Conclusion and Discussion

It can therefore be argued that today, schools certainly have a need to capture data from scientific research, but what is even more important is helping teachers and other school personnel to properly use psychological categories (such as ADHD) in their roles' objectives and in following the mandates that the schools give them.

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[**] The subjects with ADHD are treated with methylphenidate and dextroamphetamine, amphetamine-based stimulants that are pharmacologically similar to cocaine. The first (trade name Ritalin, Novartis) is usually the first choice as a drug treatment (Carey, 2004; Kremer, 2003). Another stimulant widely used is atomoxetine [Strattera-Eli Lilly, USA], (Barkley, 1998).

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